Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Lipid Lowering Agent Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for quantities greater than 30 units per month for all statins. In addition to the quantity limits, PA is required for Altoprev, Crestor, Lescol, Lescol XL, Lipitor, Vytorin and brand-name multiple-source statins that have an FDA "A"-rated generic equivalent. Additional information about statin use can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m

Member's place of residence ☐ home ☐ nursing facility

Medication information

Statins
- ☐ Altoprev
- ☐ Crestor
- ☐ Lescol
- ☐ Lescol XL
- ☐ Lipitor
- ☐ lovastatin
- ☐ pravastatin
- ☐ simvastatin
- ☐ Vytorin
- ☐ Other _____
- ☐ Brand Name* _____

*Please attach supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA Medwatch form regarding adverse reaction or inadequate response to the generic product)

Refer to section I and/or II

Fibric Acids
- ☐ Antara
- ☐ Fenoglide
- ☐ Lipofen
- ☐ Lofibra
- ☐ Tricor
- ☐ Triglide

Refer to section III

Cholesterol Absorption Inhibitors
- ☐ Zetia

Refer to section IV

Miscellaneous Agents
- ☐ Lovaza

Refer to section V

Dose, frequency, and duration of requested drug, and quantity/month

Drug or NDC (if known)

Indication for medication requested
(Check one or all that apply.)
- ☐ Hypertriglyceridemia
- ☐ Primary hypercholesterolemia
- ☐ Mixed dyslipidemia
- ☐ Secondary prevention of cardiovascular event
- ☐ Other. Specify pertinent medical history, diagnostic studies, and/or laboratory results.

Section I

Please complete for requests for quantities greater than 30 units per month.

Please provide a rationale for requested dose, quantity and frequency, including a detailed treatment plan. (Specify pertinent medical history, diagnostic studies and/or lab results.)

Is member a candidate for dose consolidation? (e.g., member is on simvastatin 10 mg BID, and dose can be consolidated to simvastatin 20 mg QD, **which does not require PA**). ☐ Yes ☐ No

Please provide rationale for a regimen of greater than one unit per day. _____

Medication information (cont.)

Section II

Please complete if request is for Altoprev, Crestor, Lescol, Lescol XL, Lipitor, Vytorin, or other.

☐ No. Explain why not.

A. Has member tried simvastatin?

☐ Yes. Complete Section VI

Section III

Please complete if request is for brandname fenofibrate (Antara, Fenoglide, Lipofen, Lofibra, Tricor, Triglide)

☐ No. Explain why not.

A. Has the member tried generic fenofibrate?

☐ Yes. Complete Section VI

Section IV

Please complete if request is for Zetia

☐ No. Explain why not.

A. Has the member tried simvastatin or fenofibrate?

☐ Yes. Complete Section VI

Section V

Please complete if request is for Lovaza

☐ No. Explain why not.

A. Has the member tried fenofibrate, gemfibrozil, and niacin?

☐ Yes. Complete Section VI

Section VI

Previous drug trial(s) Drug Name(s), dose and frequency	Dates of Use

Did the member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other

Pharmacy information

Name	Pharmacy provider no. *Optional*	Telephone no. ( )	Fax no. ( ) *Optional*	
Address		City	State	Zip *Optional*

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address *Optional*			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date